CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Canon Healthcare Hospice, LLC	**Reimbursement Determination for Cap Years Ending: 10/31/03 and 10/31/04**
Provider	
vs.	
Blue Cross Blue Shield Association/ Palmetto Government Benefits Administrator	**Review of: PRRB Dec. No. 2010-D34 Dated: June 4, 2010**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review, on own motion, of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Intermediary requesting reversal of the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Intermediary followed the proper reopening procedures prior to the issuance of the Intermediary's letter dated June 11. 2007 ("Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount") recalculating the hospice cap for years ending October 31, 2003 and October 31, 2004, respectively.

The Board held that the Intermediary failed to follow the proper reopening procedures prior to the issuance of the Intermediary's letter dated June 11, 2007. Accordingly, the Board reversed the Intermediary's determination letter dated June

11, 2007. The Board found that, while the Intermediary's notice, dated May 22, 2007 was issued within the three year reopening period, the notice lacked a complete explanation as to the circumstances surrounding the revision as required by 42 C.F.R. § 405.1887(a) and the Provider Reimbursement Manual (PRM) § 2932A. The Board rejected the Intermediary's argument that the June 11, 2007 letter satisfied the reopening provisions as it actually combined both the notice of reopening and notice of revision. The Board noted that the regulations anticipated two distinct steps with respect to reopening. First, a notice of reopening is used, which is followed by a notice of revision. Moreover, the PRM required that the notice be titled "Notice of Correction-Program Reimbursement", which the June 11, 2007 letter did not contain. Thus, the June 11, 2007 letter was ineffective as a reopening and revision to the initial determination of reimbursement.

COMMENTS

The Provider submitted comments requesting that the Administrator affirm the Board's determination. The Provider argued that CMS Transmittal No. 1226 cannot serve as a "Notice of Reopening" for the 2003 and 2004 determination because Transmittal No. 1226 only dealt with reopening of the hospice cap amount and not the inpatient day limitation. Furthermore, the notice, dated June 11, 2007, cannot serve as both a notice of teopening and a notice of revision because, prior to issuing a revised determination, the Intermediary must reopen the initial determination, and reference the initial determination in the notice of reopening. That did not occur here. Instead, the Intermediary simply issued a new determination, which is not allowed under the regulations.

Finally, the notice, dated June 11, 2007, cannot serve as a "Notice of Reopening" because the letter does not satisfy the regulatory and manual requirements for such notices. There is no reference to the prior determinations that were dated October 12, 2004, and July 15, 2005; the word "reopening" is never mentioned in the correspondence; and the notice is absent any explanation as to why a reopening or revision was necessary. The Provider argued that the June 11, 2007 letter is simply a new determination. To excuse the Intermediary's admitted failure to issue a Notice of Reopening would render the reopening requirements useless. In addition, since this case deals with inpatient day limitation, and not the cap of overall hospice payments, there has been no loss to the Medicare program in that this rule does not create true overpayments. The rule is strictly a penalty provision and does not imply that excess inpatient days are or were medically unnecessary.

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the letter, dated May 22, 2007, titled "Notification of Pending Hospice Cap Calculation" and the follow-up notice dated June 11, 2007 titled "Notice of Effect of Inpatient Day Limitation and

Hospice Cap Amount" for the cost years in dispute were procedurally sufficient to legitimize the overpayment demand.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The hospice administrative appeal provisions were established in 1983 pursuant to the December 16, 1983 final hospice rule.[1] The Secretary explained that:

> A hospice that believes an error has been made in the determination of the amount of Medicare payments may appeal the determination. Since the normal administrative appeals process under section 1878 of the Act applies only to issues related to cost reimbursement, we are creating an appeals procedure that is comparable to the statutory procedure but that is not based on section 1878. For example, the hospice may appeal the intermediary's determination as to which payment level is applicable for each day, or the intermediary's determination as to whether services provided outside the hospice program are related or unrelated to the terminal illness. The methods and standards for the calculation of the payment rates by HCFA would not be subject to an administrative appeal.
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> …. The hospice would present evidence to indicate that an error has been made in the calculations or that the intermediary did not apply the correct procedures in determining the amount of reimbursement. The hospice would also be permitted to appeal these issues to the Provider Reimbursement Review Board (PRRB) if the amount in controversy is $10,000 or more. The appeals process is set forth in 42 CFR Part 405, Subpart R. The intermediary or PRRB hearings are not appropriate for disputes involving the substance of the regulations or the law, such as the calculation of the payment amounts by HCFA.[2]

The regulation at 42 CFR 418.311 provides that:

> A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review

[1] 48 Fed Reg. 38146 (Dec. 16, 1983).

[2] *Id.* *See also* Section 408 .B of the Hospice Manual (Dated 08-87).

> from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least $1,000 or $10,000, respectively. In such a case, the procedure in 42 CFR Part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under §405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the payment rates by CMS are not subject to appeal.[3]

The Hospice payment determination appeals under 42 C.F.R. § 405.1801, et seq., are in contrast to beneficiary appeals for denials of hospice benefits under 42 C.F.R. § 405.701 *et seq*., or those circumstances where the hospice takes on the full appeal rights of the beneficiary under part 405 Subpart G (42 C.F.R. § 405.701 *et seq*.) for denial of benefits.

With respect to a determination of the intermediary, the regulation at 42 C.F.R. § 405.1885(a) states in part that:

> A Secretary determination, an intermediary determination, … may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer…, as the case may be, either on motion of such intermediary officer or panel or hearing officer, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3 year period except as provided in paragraphs (d) and (e) of this section.[4]

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[3] In 2009, the last sentence was changed to "the methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal" from the above referenced language in order to clarify that "the payment rates referred to are the national rates which are set by statute and updated according to the statute using the hospital market basket (unless Congress has instructed the rates differently)." 74 Fed Reg. 18912, 18920 (April 24, 2009).

[4] In addition, the regulation at 42 C.F.R. § 405.1885(b)(1) states in part that: "An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3 year period specified in paragraph (a) of this section, CMS--- Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the

The regulation at 42 C.F.R. § 405.1885(d) permits an intermediary reopening after the three years "if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision."

Regarding the requirements of a "notice of reopening" the regulation at 42 C.F.R. § 405.1887(a) provides that all parties to any reopening must be given written notice of the reopening. In addition, 42 C.F.R. § 405.1887(a) notes that additional written notice must be provided to all parties upon conclusion of the reopening, regarding what matter(s), if any, are being revised, with a complete explanation of the basis for any revisions. Finally, the regulation at 42 C.F.R. § 405.1887(b) requires that a reasonable period of time be given "to the parties to present any additional evidence or argument in support of their position."

Additional rules concerning intermediary reopening are addressed in §§ 2930, 2931 and 2932 of the Provider Reimbursement Manual (PRM). Section 2932 of the PRM, states that, with regard to notices of reopening and correction, the provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal.

In this case, the issue involves the Intermediary's determination on the effect of the hospice inpatient day limitation found at 42 C.F.R. § 418.302(f). Specifically, on October 12, 2004 the Intermediary issued a notice captioned Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to the Provider for cap year ending October 31, 2003.[5] On July 15, 2005, the Intermediary issued an identical letter to the Provider for the cap year ending October 31, 2004.[6] Both notices stated that the Provider did not exceed the twenty percent limitation on inpatient days, nor did it exceed the hospice cap amount and that no amount was determined to be due the Medicare program.[7] However, each of these notices included a form

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applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision."

[5] Provider's Exhibit P-1 (Case No. 08-0382). See also Intermediary's Exhibit I-2 (Case No. 08-0382).

[6] Provider's Exhibit P-1 (Case No. 08-0383). See also Intermediary's Exhibit I-2 (Case No. 08-0383).

[7] Id. "Based on this review, your hospice has not exceeded the twenty percent limitation on inpatient days; therefore, no amount is due the Medicare program."

for the calculation of the inpatient day cap overpayment amount. Each of the forms plainly showed, respectively, that not all information was recorded for the calculation to be completed. While both forms showed "Days in excess of the limit", both forms also showed $0.00 (or no dollar amount) recorded for "Medicare reimbursement for inpatient services," which resulted in $0.00 being recorded as the "total amount due the intermediary." Because of this identical error in both notices, no inpatient day limit overpayment was ever originally calculated for these years for this Provider in these notices.[8]

On May 22, 2007, the Intermediary issued a "Notification of Pending Hospice Cap Overpayment". The Intermediary notified the Provider of a "revised" review of the Hospice Cap and Inpatient Day Limitation for the 2003 and 2004 cap years. The Intermediary enclosed the calculation and the pending overpayment computation. The Intermediary advised the Provider that it had five days in which to review and submit rebuttal evidence.[9] The respective forms showing the proposed calculations actually showed a reduction in the number of days over the limit compared to the original notices, but completed the computation for the first time by including the "Medicare reimbursement for inpatient services" dollar amount, which reulsted in a determination of an overpayment due to the Intermediary. The Provider, by letter dated May 28, 2007, objected to the timeframe for reviewing the documentation

[8]On April 20, 2007, CMS issued a Medicare program Transmittal No. 1226, stating that hospice cap amount for cap period ending October 31, 2003, published July 3, 2003, and the hospice cap for period ending October 31, 2004, published August, 4, 2004, were incorrect. Intermediary's Exhibit I-3. See also, Provider's Exhibit P-4. CMS Transmittal No. 1226 directed intermediaries to reopen and recalculate the "cap" determinations for those years. Transmittal No. 1226 then listed the correct aggregate cap amounts for the subject years and, with regard to the aggregate cap calculations for cap year 2003, provided that:"RHHI, FIs and AB MAC contractors have been advised to re-compute the aggregate cap for the cap period ending October 31, 2003 for those providers whose initial cap determination is within the 3-year reopening period. The date of the cap determination letter is to be used to decide if the cap is within the 3-year reopening period…. The revised cap calculations are to be completed and the related demand letters issued by July 31, 2007."

[9] Intermediary's Exhibit I-8A (Case No. 08-0382). The Intermediary issued an identical letter to the Provider for FYE October 31, 2004. Provider's Exhibit P-8B (Case No. 08-0383). The Administrator notes that the Board granted the Intermediary's request to submit the notice dated May 22, 2007 and the Provider's response letter dated May 29, 2007. Furthermore, the Administrator agrees with the Board's determination that the Provider was not prejudiced by these submissions because they were initially introduced by the Provider as part of its preliminary position paper.

and argued that CMS was stopped from determining an overpayment for the cap years ending 2003 and 2004, because it had previously provided written notice that the Provider was in compliance with the Inpatient Day Limitations. On June 11, 2007, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" incorporating the proposed revision and advising the Provider that it was overpaid by, Medicare because it exceeded the twenty percent limitation on inpatient days for the cap years ending October 31, 2003 and October 31, 2004.

Applying the statute, regulations, and CMS policy to the fact of this case the Administrator first finds that a review of the Intermediary's October 12, 2004 and July 15, 2005 "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" for cap years ending 2003 and 2004, respectively, shows there were no inpatient day limitation calculations made pursuant to those notices in accordance with 42 CFR 418.301(f)(5). Both of these notices had attached a form. Each of the forms for the two cap years shows "days in excess of the allowable days," which are the basis for triggering such a calculation. Each of the forms showed, respectively, that the inpatient day calculation was not actually done. The "days in excess of allowable days" is followed by a notation that states "if the total number of inpatient days exceeded the allowable number of days the limitation for your agency is determined as follows." The subsequent calculation for both cap years reflect an obvious error in the failure to record any "Medicare reimbsursement for inpatient services" (or $0.00) which resulted in $0.00 being recorded as the "total amount due the intermediary." Because of this error in both notices, no inpatient day limitation and subsequent overpayment was ever originally calculated for these years for this Provider as no Medicare reimbursement for inpatient services was ever recorded as required for the calculation. Consequently, a plain error was made, which the Provider would have had the capacity and necessary information to detect in the original notices.

Moreover, an examination of the forms for the original notices compared to the overpayment notices shows that, for cap years 2003 and 2004, a change in the number of "patient days in excess of allowable days"[10] was not the reason the Provider was over the limits and subject to an overpayment as suggested by the

[10] *Compare*, e.g., October 12, 2004 notice showing 663 days in excess of allowable days compared to 662 days in the June 11, 2007 notice. The latter notice actually reduced the number of days in excess of the limits, but actually made the calculation for the first time. *See also* July 15, 2005 Notice showing 2013 days in excess of the limit compared to 1998 days in the June 11, 2007 notice. Again the latter notice actually reduced the number of days over the limit, but made the calculation for the first time.

Provider's May 28, 2007 letter. Rather, the reason the Provider was over the inpatient day limits and now subject to the overpayment pursuant to the June 11, 2007 notices was because the computation was finally done for the first time. Consequently, it would not have been unreasonable for the Intermediary to have concluded that, because of initial omission, there clearly was no inpatient day limitation computation included in the original Notices that would necessitate reopening procedures.

Second, even assuming the first Notices comprised original determination on the inpatient day limitation which required reopening, the Administrator finds that the Intermediary's letters dated May 22, 2007, captioned "Notification of Pending Hospice Cap Overpayment" satisfied the requirements of 42 C.F.R. § 405.1887. The Administrator finds that the notices of the pending revisions were made within three years of the date of notices of the Intermediary original determinations. In this case the Intermediary's original determinations were made on October 12, 2004 and July 15, 2005. The record shows that notice of pending revision were issued on May 22, 2007, well within the three years of the original determinations. Thus, the Intermediary properly notified the Provider of its intent to revise the cap years within the three year regulatory window.

Regarding the adequacy of the Intermediary Notice, dated May 22, 2007, the Administrator finds that the Provider was notified of the subject matter of the Intermediary's reopening, enabling the Provider to participate in the reopening from an informed perspective. The May 22, 2007 notice advised the Provider that the Hospice Cap and Inpatient Day Limitation for FYE 2003 and 2004 had been reviewed and errors identified. The May 22, 2007 had attached the form showing the computation for the patient day limitation. Moreover, the Provider's response letter dated May 29, 2007 shows that the Provider was aware of the subject matter of the Intermediary's reopening. The Provider stated that: "[w]e are responding to your letter of May 22, 2007 in which you advised that you had recently completed a "revised review" of the Hospice Cap and Inpatient Day Limitation for the 2003 and 2004 cap years." Thus, the Provider was notified and actually acknowledged the subject matter of the Intermediary's reopening, showing that the Provider was able to participate in the reopening from an informed perspective.

In addition, the regulation at 42 C.F.R. § 405.1887(b) requires that, "the parties to the prior decision shall be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position." In compliance with this regulation, the Intermediary's May 22, 2007 notice requested that the Provider to submit its objections and/ or comments.[11] Although the timeframe for response was compressed, the "days in excess of allowable days" in the May 22,

[11] Intermediary' Exhibit at 8A and 8B respectively.

2007 proposed revision were in fact less than the days identified in the original notices. That is, the number of days in excess of the limit was actually reduced from number of days reported in the original notices. While the Provider argued that it needed more time to examine the underlying data, the patient day data used was not the reason for the overpayment determination. Rather, the reason there was an overpayment determination was because, this time, the computation was actually performed. Moreover, since the appeal was filed, the Provider has not otherwise challenged the underlying data used in the calculation, or the substance of the calculation, demonstrating that the five day response required by the Intermediary did not adversely affect the Provider and that the reopening of the Provider's cap years for 2003 and 2004 conformed to the regulatory requirements of 42 C.F.R. §405.1887(b).

Although the May 22, 2007 and the June 11, 2007 notices did not include specific language that is set forth in §2032 of the PRM, the Administrator finds that this does not render the reopening invalid. The PRM interprets the regulations and the Intermediary complied with the regulation to the extent it is applicable to the hospice payment process. As the Intermediary noticed, the hospice payemtn process "uses different terminology, different forms and is much simpler than the reimbursement systems that falls squarely under the 405.1801(a) definition of Intermediary determination."[12] Reflective of the variances between reasonable cost reimbursement and the hospice payment system, the Secretary in 2009 clarified the regulation at 42 C.F.R. §405.1801(a)(3) to explain that the aggregate cap calculated serves as the "notice of program reimbursement."[13] Thus, historically, the hospice payment notices have used different terminology then used for other provider reasonable cost payments.

Further, the record shows that the only issue before the Board involved the Provider's challenge to the Intermediary's reopening procedures. Consequently, a remand for further decision on the merits of the revision would not be appropriate, as the Provider has not raised any substantive challenges to the calculation.

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[12] Intermediary's Comments dated July 6, 2010 at 5.

[13] 74 Fed. Reg. at 39400 (Aug. 6, 2009). "We proposed clarifying the language at § 405.1803 to note that for the purposes of hospice, the determination of program reimbursement letter sent by the contractors serves as the written notice reflecting the intermediary's determination of the total amount of reimbursement due the hospice, which is commonly called a Notice of Program Reimbursement or NPR."

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 8/2/2010

/s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services